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Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED TN1912 8. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 02/14/2012 IMPERIAL GARDENS HEALTH AND REHABILIT 308 W DUE WEST AVE MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION: (X4) ID PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY N 000: Initial Comments N 000 This Plan of Correction affirms our allegation of compliance for the During the Licensure survey and complaint deficiencies cited, however, (#0029279), conducted February 12-14, 2012, at submission of this Plan of Imperial Gardens Health and Rehabilitation, no Correction is not an deficiencies were cited under 1200-8-6. admission that a deficiency Standards for Nursing Homes. exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations. Division of Health Care Facilities ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CXBI DATE . STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1912				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING DRESS, CITY, STATE, ZIP CODE E WEST AVE TN 37115		(X3) DATE	FORM APPRO (X3) DATE SURVEY COMPLETED 02/14/2012	
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